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==07/95 ii. For rate periods described in Section B.2.b. of Chapter XVI., the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.

10/93 b. The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio as described in Section C.3. of this Chapter, exceed the greater of:

==07/95 i. For the rate period described in Section B.2.a. of Chapter XVI., $34,000 as adjusted for the hospital's labor market, or the hospital's DRG PPS base rate as described in Section B.2.a. of Chapter IV multiplied by two.

==07/95 ii. For the rate periods described in Section B.2.b. of Chapter XVI., the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission.

10/93 2. The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under Section B. of this Chapter, for discharges specified in Section D.4.b. of Chapter I., if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio as described in Section C.3. of this Chapter, exceed:

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== 10/93 a. For the rate period described in Section B.2.a. of Chapter XV., the greater of the criteria specified in Section A.1.b.i. of this Chapter.

== 10/93 b. For the rate periods described in Section B.2.b. of Chapter XV., the criteria specified in Section A.1.b.ii. of this Chapter.

== 10/93 3. The Department will not provide outlier payments for:

== 10/93 a. Discharges classified as psychiatric care (DRG's 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.

== 10/93 b. Discharges assigned to DRG's with an Illinois weighting factor of zero (0.0000).

== 10/93 4. The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as noncovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:

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a. The admission was medically necessary and appropriate.

b. The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.

c. The services were ordered by the physician, actually furnished, and nonduplicatively billed.

d. The validity of the diagnostic and procedural coding.

e. The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a nonacute patient.

09/91 B. Payment for Extended Length-of-Stay Cases (Day Outliers)

10/92 1. If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG's 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.

==07/95 2. Except as provided in Section D. of this Chapter, and subject to the limitations described in Section E. of this Chapter, the per diem payment made under Section B.1. of this Chapter, is derived by first taking the marginal cost factor, as defined in Section B.8., of Chapter XVI, of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section B.2.c. of Chapter IV. by the mean length-of-stay for that DRG.

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== 10/93 3. Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.

09/91 C. Payment for Extraordinarily High Cost Cases (Cost Outliers)

10/92 1. If the hospital charges, as adjusted by the method specified in Section C.3. of this Chapter, exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.

== 10/93 2. The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in Section C.3. of this Chapter, subject to the limitations described in Sections C.4. and E. of this Chapter.

== 10/93 3. The cost-to-charge ratio used to adjust covered charges is computed at the beginning of each rate period, as described in Section B.2. of Chapter XV., by the Department for each hospital based on the hospital's base fiscal year. Statewide cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).

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4. If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

==07/95 5. For the rate periods described in Section B.2. of Chapter XVI, the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers.

09/91 D. Payment for Extraordinarily High Cost Day Outliers

If a discharge qualifies for an additional payment under the provisions of both Sections B. and C. of this Chapter, the additional payment is the greater of the following:

1. The payment computed under Section B. of this Chapter.

2. The payment computed under Section C. of this Chapter.

10/93 E. Outlier Payment Limitation. Notwithstanding any other provisions of this Chapter, the total reimbursement paid by the Department for a claim qualifying for an outlier payment under this Chapter shall not exceed the total covered inpatient charges.

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VI. Special Treatment of Certain Facilities

09/91 A. General Rules

09/91 1. Sole Community Hospitals

10/93 Hospitals defined as sole community hospitals under Section B. of this Chapter, shall have the choice of being reimbursed under the DRG PPS methodology, as described in Chapters I. through VII., or the Department's Alternate Reimbursement methodology as described in Chapter VIII., in accordance with the provisions of Sections H. through J. of Chapter VIII.

10/92 2. Hospitals that Serve a Disproportionate Share of Low Income Patients

10/93 The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in Section C. of this Chapter.

==07/95 3. Specific Inpatient Payment Adjustments. The Department shall make specific additional payments to applicable hospitals as set forth in Sections E. through F. of this Chapter and Chapter XV.

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09/91 B. Special Treatment: Sole Community Hospitals

1. Criteria for Classification as a Sole Community Hospital

"Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:

10/93 a. Medicare Program Designation

10/93 i. For the rate period described in Section B.2.a. of Chapter XV., any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992.

ii. For the rate period described in Section B.2.b. of Chapter XV., any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective 90 days prior to the date of admission.

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== 10/93 b. Primary Service Area Designation

== 10/93 i. Any rural hospital, as described in Section B.3. of Chapter XV., that serves 55 percent or more of the Medicaid patients residing within the hospital's primary service area for the provision of inpatient hospital services.

== 10/93 ii. "Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.

== 10/93 iii. The determination of sole community provider status under this Section B.1. shall be made prior to the rate period, as described in Section B.2. of Chapter XV.

== 10/93 iv. The data used to make this determination will be from the Illinois Health Care Cost Containment Council (IHCCCC) for the most recent four quarters for which information is available.

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07/91 C. Special Treatment: Hospitals That Serve a Disproportionate Share of Low Income Patients

==03/95 1. Qualified Disproportionate Share Hospitals (DSH)

Disproportionate Share (DSH) adjustments for inpatient services provided prior to October 1, 1993, shall be determined and paid in accordance with State plans governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 1993, and each October 1, thereafter, unless otherwise noted. For inpatient services provided on or after October 1, 1993, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

10/92 a. The hospital's Medicaid inpatient utilization rate, as defined in Section C.8.e., is at least one half standard deviation above the mean Medicaid inpatient utilization rate, as defined in Section C.8.c.

==03/95 b. The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children, Transitional and Interim Assistance (formerly known as General Assistance), Aid to the Medically Indigent (AMI) and/or any local or state government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children, Transitional, and Interim Assistance (formerly known as General Assistance), AMI inpatient hospital services, and/or any local or state government-funded care) must be added.

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== 10/93 c. Illinois hospitals that, on July 1, 1991, had a Medicaid inpatient utilization rate, as defined in Section C.8.e., that was at least the mean Medicaid inpatient utilization rate, as defined in Section C.8.c., and which were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CRF, 5, 1989).

10/92 d. Illinois hospitals that:

10/92 i. Have a Medicaid inpatient utilization rate, as defined in Section C.8.e., which is at least the mean Medicaid inpatient utilization rate, as defined in Section C.8.c., and

10/92 ii. Also have a Medicaid obstetrical inpatient utilization rate, as defined in Section C.8.f., that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in Section C.8.d.

10/92 e. Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children.